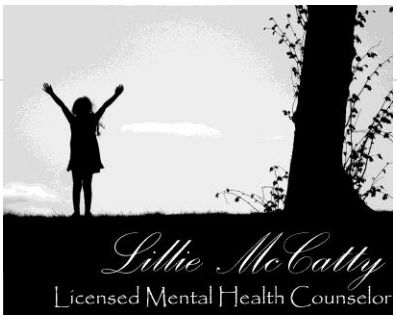


Demographics:

Your Name: _____

Birthdate: _____ Age/DOB: _____

Others who live in your home: _____

_____

Phone Number(s): Address:

_____ _____

_____ _____

Any other agencies or therapists involved with your family:

_____

_____

_____

Mental Health:

Briefly describe the reasons you have come to counseling today:

_____

_____

_____

Describe any prior counseling and what, if any, prior diagnoses you have received:

_____

_____

_____

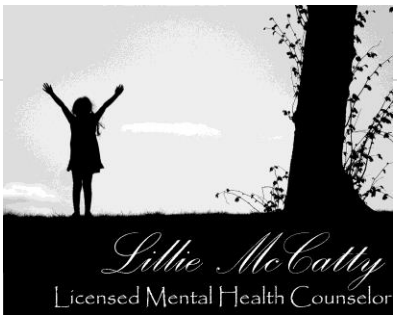
Medications you currently take and who prescribes them?

_____

_____

_____

Adult Intake and Background



Circle any major events or traumas you have experienced:

Recent move
Recent change in family finances
Separation or divorce
Change in custody agreement
Loss of a loved one
Physical abuse
Neglect
Sexual abuse or rape
Surviving a natural disaster
Head injury
Painful or scary medical treatment
Serious car accident
Hearing about or witnessing a violent death
Known someone who committed suicide

Rate any symptoms you are experiencing on a scale from 1-3 where 3 is the most serious:

___ Nightmares
___ Trouble falling asleep
___ Trouble staying asleep
___ Become upset when reminded of the past
___ Unwanted thoughts
___ Avoiding certain people, places, or things
___ Less interested in doing things
___Trouble feeling close to others
___ Never seem to cry or cry all the time
___ Significant loss or gain of weight
___ Change in appetite
___ Feeling hopeless
___ Irritable
___ Fits of anger
___ Trouble paying attention
___ Being overly careful
___ Jumpy or easily startled
___ Fidgety
___ Can't sit still
___ Easily distracted
___ Difficulty waiting turns
___ Trouble following directions
___ Interrupt or blurt out answers
___ Cannot stay with one activity long
___ Talk all the time
___ Trouble listening
___ Often lose things
___ Do things without thinking first
___ Risky behavior
___ Feeling sad
___ Feel discouraged or like a failure
___ Feelings of guilt
___ Self Harm or Cutting
___ Think about or have attempted suicide
___ Trouble making decisions
___ Trouble with self-esteem or body image
___ Can't seem to get motivated
___ Can't follow through on tasks or commitments
___ Tired during the day
___ Worry a lot
___ Daydream too much
___ Starts fights with others
___ Not following rules or complying with requests
___ Trouble understanding other people's feelings
___ Teasing others
___ Blaming others
___ Take things that do not belong to me
___ Destroying property
___ Setting fires
___ Sexually inappropriate behavior
___ Tired
___ Restless
___ Panic or Anxiety Attacks
___ Trouble leaving my home
___ Trouble attending school or work
___ Often argue with authority figures
___ Deliberately annoy others
___ Refuse to eat or throw up to lose weight
___ Others: _____

Comments on any of the above:
_____
_____
_____
_____
_____
_____
_____

Interpersonal and Social Skills:

Do you have concerns about you interactions with others at work or home or with your ability to make and keep friends?

Physical Health:

Your doctor:
Name:
Contact Information:

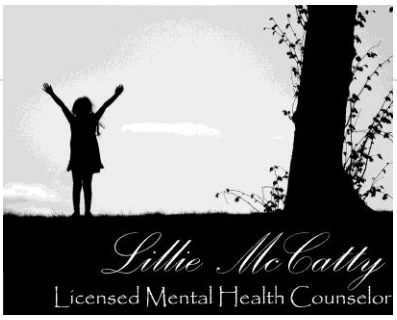
Any special dietary restrictions or allergies:
_____
_____
_____

Any chronic physical health concerns now or in the past? (asthma, diabetes, pain, etc.)
_____
_____
_____

Has anyone ever told you that you have any kind of delays or impairments?
_____
_____
_____

Any history of major illness or surgery?
_____
_____
_____

Have you ever caused, threatened to cause, or attempted to cause deliberate harm to yourself or anyone else?
_____
_____
_____



Substance Abuse:

Are substances an issue in your life now or in the past?
(Include both legal and illegal substances as applicable)

_____
_____
_____

Would you be receptive to a substance abuse treatment referral? _____

Vocational/Educational:

What the highest grade you completed? _____
Talk a little about your work history:

_____
_____
_____

Do you have a history of being in trouble at work?

_____
_____
_____

Family:

Please tell me a little about your family history:

_____
_____
_____
_____
_____
_____

Please describe your natural support system:

_____
_____
_____

Cultural and Spiritual:

To what race, ethnicity, or culture do you identify? _____

Tell me about the ways in which you participate with your culture:

_____
_____

Does your family subscribe to a particular spiritual background or attend church regularly?

_____
_____
_____
_____
_____

Describe your sexual identity/orientation (include any concerns):_____
_____
_____

Are you concerned about ways in which cultural, spiritual or sexuality issues may affect your counseling?

_____
_____
_____

Legal Involvement:

Do you currently have any involvement with any court system including criminal and family courts?

_____
_____
_____

Your Goals:

Describe what you would like to get out of your in counseling?

_____
_____
_____